

0401: PERINEAL RECTOSIGMOIDECTOMY FOR RECTAL PROLAPSE

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Introduction: Rectal prolapse is a condition that mainly occurs in older women. We evaluated the morbidity, mortality, recurrence rate and functional results of the perineal rectosigmoidectomy.

Methods: All patients who underwent a perineal rectosigmoidectomy between 2004–2011 in a tertiary referral center were included. Symptoms pre-and postoperatively, length of specimen after fixation in formalin, postoperative hospital stay, 30 days morbidity and mortality, and recurrence were determined.

Results: Forty-one patients were included. Forty (93% female) with a mean age of 78 ± 13 years. Eight (20%) had a recurrence of a previous perineal rectosigmoidectomy. In most patients, Altemeier procedure performed only in two patients Delorme procedure. Symptoms were: 69% feeling of rectal mass, 24% painful defecation, 50% faecal incontinence, 31% constipation, 19% rectal bleeding. Postoperatively, these symptoms were present in 24%, ($p < 0.001$), 13%, 29% ($p = 0.028$), 17% and 4% respectively. Average length of resection specimen was 8.9 ± 3.8 cm, mean post-operative hospital stay was 10.6 ± 12.2 days. Complications were seen in 6 (15%) patients. Recurrence was seen in 5 (13%) patients. No deaths reported.

Conclusions: The perineal rectosigmoidectomy is a safe procedure for old, frail patients with low mortality, morbidity and recurrence rate, with good functional results.

0402: SPECIALIST PHYSIOTHERAPY FOR FAECAL INCONTINENCE – LONG-TERM FOLLOW UP

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Introduction: This study is aimed to assess the initial impact and long term outcome of specialist pelvic floor physiotherapy.

Methods: Prospective study of patients undergoing specialist physiotherapy (including Biofeedback, structured pelvic floor training etc.) at a specialized unit of a teaching hospital between 2009 – 2010. Patients were objectively assessed with Wexner and faecal incontinence quality of life (FIQL) questionnaires.

Results: Total forty-two patients seen between 2009–2010. Twenty-eight included. Twenty-six (93%) were women and two men (7%) with a median age of 75 years (range 27–79). The initial Wexner and FIQL scores were compared with scores at discharge and at six months post discharge. Median follow up 13 months (range 7–17 months) The mean Wexner score at initial visit was 9.71 ($n=28$), at discharge was 4.00 ($n=24$) and at final visit was 5.82 ($n=28$) the improvement was statistically significant ($p < 0.05$) at both visits. The mean FIQL at initial visit was 3.04 ($n=27$), at discharge 3.57 ($n=23$) and at final visit was 3.48 ($n=27$), this was statistically significant ($p < 0.05$) on both visits. Statistical test used, paired 't' test.

Conclusion: Specialist pelvic floor physiotherapy is an effective means of treating faecal incontinence and the results are sustained at long follow up.

0440: FOLLOW UP COLONOSCOPY IN UNCOMPLICATED DIVERTICULAR DISEASE – IS IT NECESSARY?

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Aim: It is a widely accepted view amongst general surgeons that routine outpatient colonoscopy is arranged approximately 6 weeks after admission with acute diverticulitis. The aim of this research project was to establish whether routine follow up with colonoscopy is necessary for all patients with a clinically uncomplicated presentation of diverticular disease confirmed on CT scan during admission.

Method: Patients from 1st January 2011 to 1st January 2012 in Glasgow Royal Infirmary with acute diverticular disease were included. Those patients with uncomplicated clinical presentations confirmed by CT scan were highlighted and their follow up colonoscopy reports analysed.

Results: One hundred and fifty patients with a clinically and radiologically uncomplicated picture of acute diverticular disease were assessed. 30% were still followed up with routine colonoscopy with 80% showing simple diverticular disease and 20% showing simple polyps. No malignancies were found.

Conclusion: Routine colonoscopy following an episode of acute uncomplicated diverticulitis, confirmed with CT scan does not appear to change management of this patient group. Whilst it may be necessary for follow up in specific population groups (i.e. strong family history of colon cancer), it is not essential for every patient in this cohort and is of great expense to the NHS.

0462: PRE-OPERATIVE ALBUMIN LEVEL IS ASSOCIATED WITH LENGTH OF HOSPITAL STAY IN PATIENTS UNDERGOING COLORECTAL CANCER SURGERY

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Introduction: Previous studies show that pre-operative neutrophil:lymphocyte ratio (NLR), albumin and haemoglobin are useful prognostic indicators in patients undergoing colorectal cancer surgery. Our objective was to assess how these factors influenced post-operative complications and length-of-stay (LOS) in these patients at a district general hospital.

Methods: A retrospective analysis was undertaken of all patients undergoing colorectal cancer surgery between 2009–2010. Hospital archive systems were used to ascertain: NLR, albumin and haemoglobin levels. Complications were retrieved from the cancer-services database; and LOS was calculated from discharge documentation.

Results: Of 196 patients, 60.7% were male; with a median age of 72.1 years (range 37–92). Complications included 8 anastomotic leaks and 14 in-hospital deaths. Median LOS was 10 days (range 1–378). The only independent predictor of complications on multivariate analysis was whether operations were performed as an emergency (OR 4.37; 95%CI 1.60–11.97; $P=0.004$). Age was positively correlated with LOS ($r^2=0.220$; $P=0.001$); albumin levels were inversely correlated with LOS ($r^2=-0.176$; $P=0.007$).

Conclusions: NLR is not predictive of complications or associated with LOS following colorectal cancer surgery. Pre-operative albumin, a traditional marker of nutritional status, was associated with length of hospital stay. Greater emphasis should be placed on addressing nutritional deficiencies preceding elective colorectal cancer surgery.

0478: EARLY WOUND COMPLICATIONS AFTER ABDOMINOPERINEAL EXCISION OF THE RECTUM FOR MALIGNANCY. COMPARING CLOSURE TECHNIQUES

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Introduction: Abdominoperineal excision of the rectum (APER) for low rectal and recurrent anal malignancy may be associated with significant perineal wound morbidity. We discuss our experiences of primary closure, biological mesh and flap reconstruction for perineal closure.

Methods: The data was collected retrospectively for all patients undergoing APER for malignancy between 2007–2012, at a single institution. This included wound complications, notably wound dehiscence, flap necrosis, cellulitis and abscess formation.

Results: APER was performed in 47 patients, 25(53%) received neo-adjuvant chemoradiotherapy. 8(17%) patients underwent biological mesh perineal reconstruction, of which only 2(25%) patients developed wound dehiscence. 22(47%) underwent primary closure, of which 6(27%) developed wound dehiscence, 1(4.5%) developed tissue necrosis, 1(4.5%) developed abscess formation and 3(13.6%) developed cellulitis. 17(36%) had a perineal flap (IGAP or VRAM) of which, 7(41%) developed wound dehiscence, 3(17.6%) developed flap necrosis, 3(17.6%) developed cellulitis and none abscess formation.

Early perineal complications occurred in 2/8 patients after biological mesh, 11/22 after primary closure and 13/17 after flap reconstruction. There was a significant difference in biological mesh vs. flap groups ($P < 0.05$).

Conclusions: Biological mesh closure can result in successful perineal healing with minimal early complications. A larger study of biological meshes is required to further evaluate this technique for perineal closure.

0522: A RETROSPECTIVE COHORT STUDY OF ANAL INTRAEPITHELIAL NEOPLASIA GRADE 3

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